Access, Screening, Triage, and Referral Protocols, Standards and Documentation Requirements, Uniform Portal Design, and Staff Qualifications Requirements

4.0 Introduction

The North Carolina State Plan 2003: Blueprint for Change states that system entry (screening, triage and referral) should assure ease of access organized through the Local Management Entity (LME) in order to respond to community members as quickly and accurately as possible. This includes a brief screening and triage in order to determine if a MH/DD/SA problem exists, to assess the urgency of the situation, and to make an initial determination as to type of problem and target population status so that a referral can be made to an effective service. This follows the Plan's value of a "No Wrong Door" which states that there must be many avenues of access where people can enter the system in a manner that is customer-service oriented in approach and exhibits a genuine desire to help those who enter. The Person Centered planning and thinking process is interwoven throughout the system and begins with the first contact the individual has with the system. The concept of uniform portal, described below, establishes the expectation of a consistent statewide process for entering and leaving the public service system that supports and facilitates access to services no matter where the person enters. Proposed standards for access to services are outlined below and allow the LME and it's providers to respond to people in an appropriate and timely manner. Following the access standards, the elements making up an acceptable screening and triage protocol are presented along with the qualifications of staff performing these functions. The elements necessary to screen individuals seeking services is presented. Thus, the access, screening, triage, and referral process will be standardized and performed according to consistent statewide protocol whose elements are listed below. It is recognized that some LME's will need to build their crisis capacity.

4.1 Access:

Access is defined as where and how someone makes initial contact with the MH/DD/SA system. Access is determined by the urgency of need assessed. This will be emergent, urgent, or routine. The goal is to resolve the crisis/situation in a proactive and supportive way that engages the consumer, family, or other support persons and ultimately engages the person into services. Access has to be a very responsive system that is focused on "consumer risk reduction" and works to remove burdens or barriers on the consumer or family to get the help that is needed. Emergent, urgent and routine should be defined in the LME contract.

4.1.1 Access Standards:

- Emergent response: consumers with life threatening/non life threatening emergency needs will be seen immediately or within one hour or 911 will be called if indicated.
    - Urgent response: consumers will be seen within 48 hours.
    - Routine response: care must be provided within 7 calendar days. However, consumers will be seen the same day the service is requested if:
        - there is an available appointment that day.
        - The consumer would like to wait for a possible cancellation.

- A uniform portal shall exist whereby the same elements exist for access regardless of where the person enters the system (i.e., walk-in, statewide toll free line, LME, provider).

- The response is immediate in that the telephone is answered in three rings or less.

- Consumers will have telephone access to a live person able to respond with the ability to screen and refer 24/7. TTY service will be available for individuals who have deafness or are hard of hearing. Foreign Language Interpretation capabilities, including sign, will also be available.

- The person initially answering the call will be a staff person qualified to provide screening services.

- The telephone system must have electronic caller identification and call tracing.

- The person initially answering the call must have the ability to get help from staff when needed to manage the call.

- If the person has transportation issues that prevent access, the LME will work with the family, local community, and others to develop resources to address this issue.

- The person initially answering the call is qualified to assess the priority of the call according to written procedures.

- Telephone abandonment rates or overflow to voice mail are not to exceed 5% at any given time.

- Walk Ins to the LME or a service provider
  - An LME staff person qualified to provide screening will see the consumer within 15 minutes from time of walk in to perform the screening and triage. The screening and triage is to determine the existence of a MH/DD/SA need, determine the urgency of this need, and to triage the need into an emergent, urgent, or routine level.
  - If the consumer presents in person at a service provider and has not been referred by the LME, the provider should contact the LME and allow the person to receive the screening, triage, and referral by the LME over the phone in order to secure authorization to perform further services as indicated.

- Telephonic presentation to the LME or a contracted service provider
  - If the consumer telephones the LME directly the protocol is the same as when the call comes to the statewide toll free number.
  - If the consumer telephones the service provider directly, the provider should refer the caller to the LME.

- On-line or Web based contact

- The staff person receiving this contact will refer the contact to the appropriate LME as soon as possible but not later than one hour after receiving/opening the contact.

- Contact with other local agency
  - Information will be offered to other agencies to assist in training them to refer requests for MH/DD/SA services to the appropriate LME
  - The individual will be referred to the LME for screening.
  - There is no wrong door within the MH/DD/SAS system.

- Telephonic presentation to the statewide toll free number
  - There is a statewide toll free number, which will read electronically the caller's area code and telephone prefix and automatically route that call to the appropriate LME. Each LME operates (or may contract for) an access line that is staffed 24/7 with live, qualified staff. These lines receive calls routed from the statewide server and calls made directly to local access line.

- Telephonic presentation to the LME access line
  - This line is to be live-staffed 24 hours a day 365 days a year.
  - Calls are answered by the third ring.
  - Calls are directed to qualified staff who have been training and privileged to perform screening, triage, and referral.

- The LME will have or contract for a Crisis Emergency System that may involve several models of crisis response (e.g. on-call staff, mobile crisis team, clinic or facility based crisis screening). All components of the Crisis Emergency System are staffed by clinicians. Telephonic clinical triage of the problem to determine which type of crisis response is required. The following list is not exhaustive.
  - Telephonic crisis intervention counseling, as appropriate.
  - Dispatch mobile crisis team, if exists and as appropriate.
  - Dispatch on-call staff to the emergency room as appropriate
  - Arrange for inpatient assessment and admission, or alternative hospital admissions placements.
  - Liaise with local law enforcement in situations where needed.
  - Maintain Crisis Plans on file for active consumers, including contact information for current case manager or primary clinician in the qualified provider network.
  - 23 hours observation bed
  - emergency respite

4.1.2 Access Staff Qualifications:

- Staff credentialed by the LME to perform the access function.

4.2 Screening and Triage:

Screening involves a brief interview designed to first determine if there is there a MH/DD/SA need and if the need emergent, urgent, or routine. Secondly, screening will offer an initial determination as to whether or not the caller appears to be a member of a target population. Finally, the triage provides an initial diagnostic determination and an appropriate referrals for the consumer.

4.2.1 Screening and Triage Standards:

- A uniform portal shall exist whereby the same elements exist for screening and triage regardless of where the person enters the system (i.e., walk-in, statewide toll free line, LME, provider). Screening and triage is the responsibility of the LME but this may be contracted and/or connected to a crisis service. If someone enters through any door, they will be referred to the LME screening and triage service and the protocols for that service will be uniform across North Carolina.
- Access, Screening & Triage Staff will offer an initial determination as to whether or not the caller appears to be a member of a target population.
- Access, Screening & Triage Staff will maintain a call log that minimally includes basic identifying information, referral source, type and time of call, assessment of risk and disposition.
- Access, Screening & Triage Staff will gather the demographic information named in the documentation section below using a customer friendly interview format.
- Access, Screening & Triage Staff will document discussion of referral options with the consumer and/or family.
- Access, Screening & Triage Staff will document the referral(s) made.
- One hundred percent of new consumers experience the screening function as a part of a caring and person centered process. Current consumers are not required to under go screening to continue with current service providers, until a new Person Centered Plan is developed with consumer knowing a range of choices

- Screening/triage decisions made at local hospitals should be made by Qualified Clinical Professionals assisting the ER in making decisions with an on-call psychiatrist providing backup.
    - Staff must be knowledgeable and able to deal with issues of involuntary commitment and a person's ability or lack thereof to give informed consent.
    - Staffing should take into account high volume times and staff accordingly.
    - Consumers should not be required to undergo multiple intakes or screenings.
    - Consumers need to get to the point of assessment and service as quickly as possible. The goal is to avoid duplications of both the screening and assessment functions.
    - Consumers presenting in person must be continually observed until qualified clinical staff sees them.

4.2.2 Screening and Triage Protocol:

Procedure:

- All calls to the LME are answered by the third ring, if not by a clinician then the receptionist, who will send the call through to the first available clinician.
    - Clinician immediately determines if call is Emergent, Urgent, or Routine.
    - Caller requesting basic information or referral outside system is referred as needed.
    - Clinician begins to complete the triage template, which is completed with every triage call.
    - Clinician records date and time of call.
- The clinician takes the following information from the consumer (or their guardian) during the phone call:
    - caller name and relationship to consumer if not the consumer
    - caller phone number
    - consumer name, date of birth, phone number
    - determine whether the consumer is court ordered, court involved, or in custody (if in custody, get the guardians name and phone number)
    - determine whether consumer had been seen previously or is open with the LME or a provider.
    - Nature of/reason for call and diagnosis if known

- Information gathered in the screening process should be forwarded to the provider receiving the referral.

- Non Clinical Needs – If the call is regarding a non clinical need and no threat exists, the response is treated as routine and care is provided as soon as possible within that standard.

- Emergent Calls - If call is Emergent (a caller with a life-threatening or with non-life-threatening emergency):
    - Caller is immediately transferred to the crisis clinician for telephonic clinical triage. The receptionist remains on the line until the clinician has engaged the caller.
    - Caller needs to be seen within one hour.
    - Family or friends will be included if requested by the consumer.
    - If indicated the clinician immediately refers the caller to the emergency room or crisis facility of the caller's choice for an emergency evaluation, or to the Magistrate if commitment is apparent. Clinician will also call 911 to request assistance if indicated.
        - referral information is recorded
        - clinical follows up with phone call to referral source
        - follow-up is recorded
    - For persons being evaluated for commitment, relationships with local law enforcement is encouraged to ensure the transportation of individuals to screening locations and to have the officer stay with the consumer during the first level commitment screening.
    - Efforts should be made to determine if there are advance directives under GS 122C-77.

- Urgent Calls - If the call is determined to be urgent the following apply.

- Care must be provided within 48 hours.
- The provider network must be organized in a manner that facilitates timely access to services and supports. Each LME will be expected to meet the standard of having services available to residents of the catchment area within 30 minutes drive time or 30 miles distance. Exceptions to this standard exist when a community has no medical or mental health resources within the 30 minute or 30 mile benchmark.

- Routine Calls: - If the call is determined to be routine the following apply.
  - Care must be provided within 7 calendar days.
  - Clinician schedules the face to face assessment.
  - Caller is told that if the consumer is in the custody of an adult or legal guardian, the legal guardian/parent/custodian must come with the consumer to the face to face assessment except for persons seeking outpatient SA treatment.
  - Consumer can also call to make his/her own appointment after the referral has been entered for the provider.
  - Access, Screening & Triage Staff completes all documentation according to protocols.

4.3 Access, Screening & Triage Staff Qualifications:

- Staff performing the screening, triage, and referral service should be qualified professionals with a bachelor's degree and MH/DD/SA training who are credentialed to provide these services and to give a dispositional diagnosis.
- These staff are supervised by an on-site masters level clinician.
- Qualified clinicians must be trained in crisis intervention and other behavioral health emergency techniques, including assessment and Therapeutic Physical Intervention.
- Any LME or contracted providers performing triage and screening functions should have staff that include at a minimum:
  - Two clinical Access, Screening & Triage Staff
  - A psychiatrist for oversight who is available on-call
  - Rapid access to the on-call clinical staff is necessary when demand is high.
  - A Certified Substance Abuse Counselor must be a part of the team.
  - A qualified professional who has experience in developmental disabilities must be a part of the team.

4.4 Documentation Requirements for Screening and Triage

There shall be documentation to demonstrate that an individual who initiates contact for MH/DD/SA services has been assessed for the purpose of determining the nature of the individual's problem(s), condition, or need(s) for services and supports. Screening/Triage Forms may be developed. The form may incorporate the call log, screening/triage information, referral and disposition. The following elements shall be included:

Call Log for Screening

The Call Log for screening must include the following elements: Basic identifying information, referral source, type of call, assessment of risk and disposition. Staff shall gather the following demographic information:

- Consumer Name (first, MI, last, and maiden)
- Caller name if other than consumer and relationship to the consumer (first, MI, last)
- Parent's name or Guardian (if applicable)
- Address (Home address as well as location from where the call is placed)
- Home Phone (determine if okay to call or not)
- Work Phone (determine if okay to call or not)
- Date of Birth
- Gender
- Referral Source
- Nature of problem and diagnosis if known
- Case manager (if applicable, including determination of open record with LME or provider)
- Where referred following triage
- Emergency contact information name and phone
- Custody, court ordered, or involved information (if applicable)

Accommodations for physical, language, or cultural barriers

- Transportation availability to get to referral

The following clinical information shall be documented at the time of assessment:

- Presenting problem
- History of presenting problem
- Prior treatment history
- Support Systems
- Suicidal ideation and/or attempts
- Evidence of current or past domestic violence or abuse
- Current violent ideation or behavior
- History of Substance Abuse
- Drug of Choice
- Frequency of Use
- Route of Administration
- Clinical Impression

4.5 Referral:

Referral is the procedure by which the screening professional and the consumer choose a clinically appropriate provider and facilitate the consumer's successful contact with that provider so that services can be initiated. The person centered philosophy is an integral part of this process as the individual's needs and wishes are the center of the process. Inherent in screening is the function of referral. This is true for those who have no MHDDSA need as well as for those with needs that are appropriate for further

assessment. It is the function of the LME to coordinate the individual's care from the time the referral is made to the time the person is seen by the provider. This should include a follow up with the provider to ensure that the individual was seen as referred. In situations where there is some safety risk during this transition, it is the responsibility of the LME to take the steps necessary to ensure the safety of the individual. One part of the referral is the authorization of the assessment and initial clinical services which is performed by the LME or its designee.

4.5.1 Referral of Target Populations:

For person's screened to be in the target population, the referral is to a provider who will perform an intake assessment and develop the Person Centered Treatment Plan (PCP) utilizing the enhanced benefits. The screening professional will enter an authorization for these services. If the intake assessment suggests that the person is not in a target population, the provider will contact the LME for a referral to an appropriate level of service.

4.5.2 Referral of Non-Target Populations:

For person's screened to not be in the target population, the referral is to a provider who will evaluate and offer treatment services utilizing the basic benefits. The referral might also be to a community self help or peer support organization. If a referral is to be to a provider for further assessment and possible treatment, the screening professional will enter the authorization for these services. If the evaluation suggests that the person is a member of a target population, the provider will contact the LME for a referral to an appropriate level of service.

4.5.3 Referral Standards:

- The provider network must be organized in a manner that facilitates timely access to services and supports. Each LME will be expected to meet the standard of having services, as designated in rule, available to residents of the catchment area within 30 minutes drive time or 30 miles distance. Exceptions to this standard exist when a community has no medical or mental health resources within the 30 minute or 30 mile benchmark. LME's are expected to work with their community in advocating for adequate transportation of person's with MH/DD/SA to attend treatment. Exceptions to the standard will be approved by the LME.
- The referral should take into account and make every effort to accommodate consumer choice whenever possible.
- The referral shall be to a provider deemed to be qualified to treat the issues that appear to be present based on the screening.
- The screening clinician shall be able to offer a specific appointment time to the individual.
- The provider must be able to offer first level toxicology screening.
- The authorization should be to a masters level outpatient clinician or to the responsible professional in a treatment team.

4.5.4 Referral Protocols:

- The screening clinician must have access to current appointment times with providers of choice.

- Screening unit makes “active linkage” of caller to a service provider; schedules an appointment for an intake assessment. LME Access, Screening & Triage Staff makes a follow-up call with the individual to assess whether linkage occurred.
- Client rights and customer service material will be available on the first visit to the provider.

4.5.5 Referral and Disposition Documentation Requirements:

- Screening staff will document discussion of referral options with the consumer and/or family.
- Screening staff will document the referral(s) made.
- Screening staff will sign and date document.
- Document follow up contact to assure linkage.
- Signature of staff completing follow up and date.